

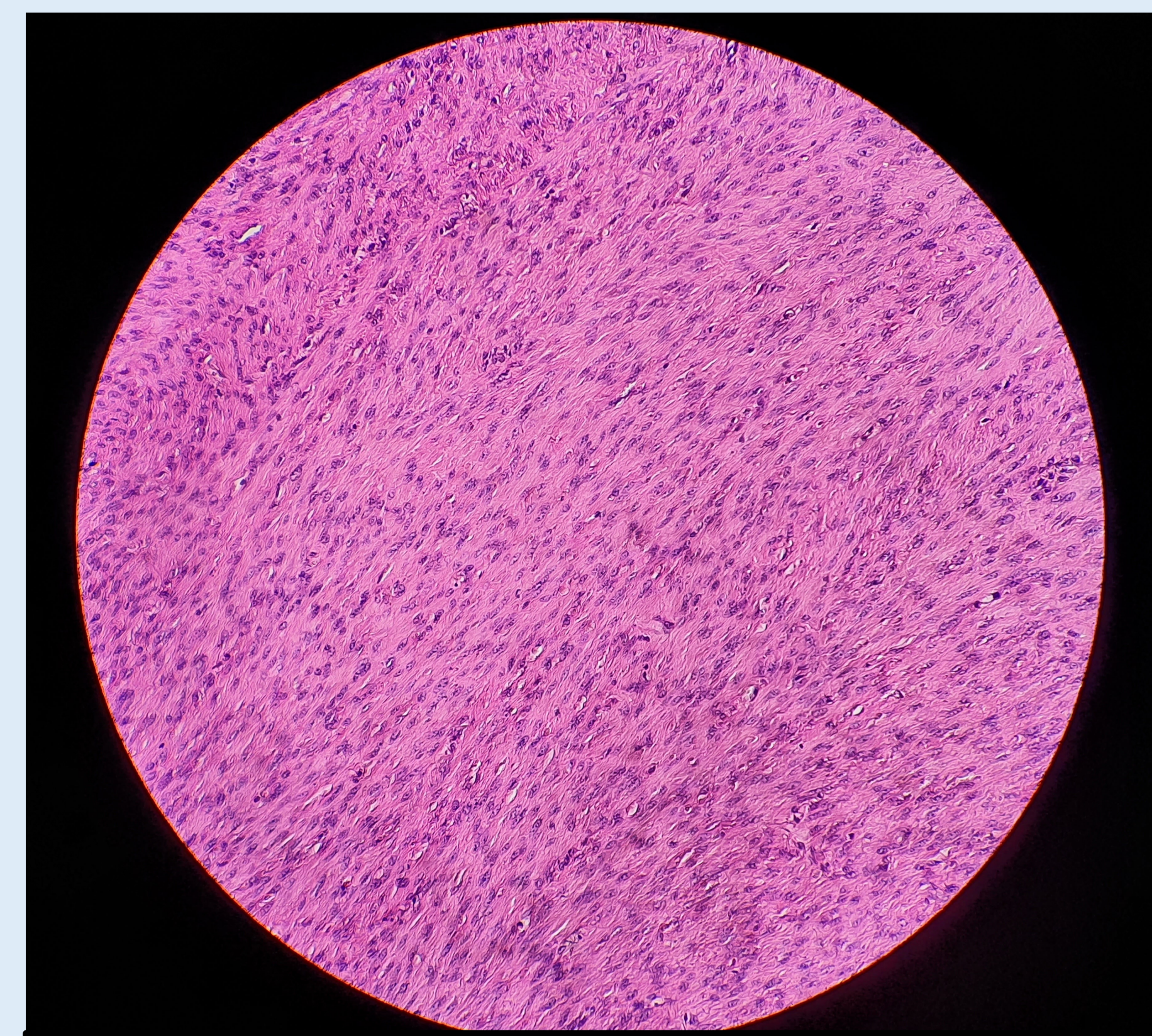
A Rare Case of a Posterior Vaginal Wall Leiomyoma

Z Sanusi, B Subba, U Wokoh, A Pradhan

North Middlesex University Hospital, London

OBJECTIVE

To highlight a rare case of a vaginal wall leiomyoma, and give guidance for their investigation and management.



Histological appearance of benign leiomyoma

CASE STUDY

A 40-year-old multiparous woman of Indian origin presented to the Gynaecology clinic with a six-month history of a vulval-vaginal lump. Clinical examination noted a non-tender, non-fluctuant mass of 4 x 4cm, protruding from the posterior vaginal fourchette. The overlying vaginal epithelium appeared normal. This mass was considered to be a Bartholin's cyst. She was listed for a Marsupialisation under General Anaesthesia.

At the time of incision, the mass was noted to be solid. This mass was located behind the left lateral vaginal wall, and anterior to the rectum, extending superiorly. Colorectal surgeons were asked to attend, due to concerns of rectal involvement. The mass was removed as a single tumour, and measured 93mm once removed. The post-operative recovery was uneventful. Histopathology revealed a well-differentiated smooth muscle mass with no tumour necrosis. The mitotic activity was low, and no atypical forms were seen. After consultation with histopathologists at a tertiary centre, the mass was concluded to be a leiomyoma.

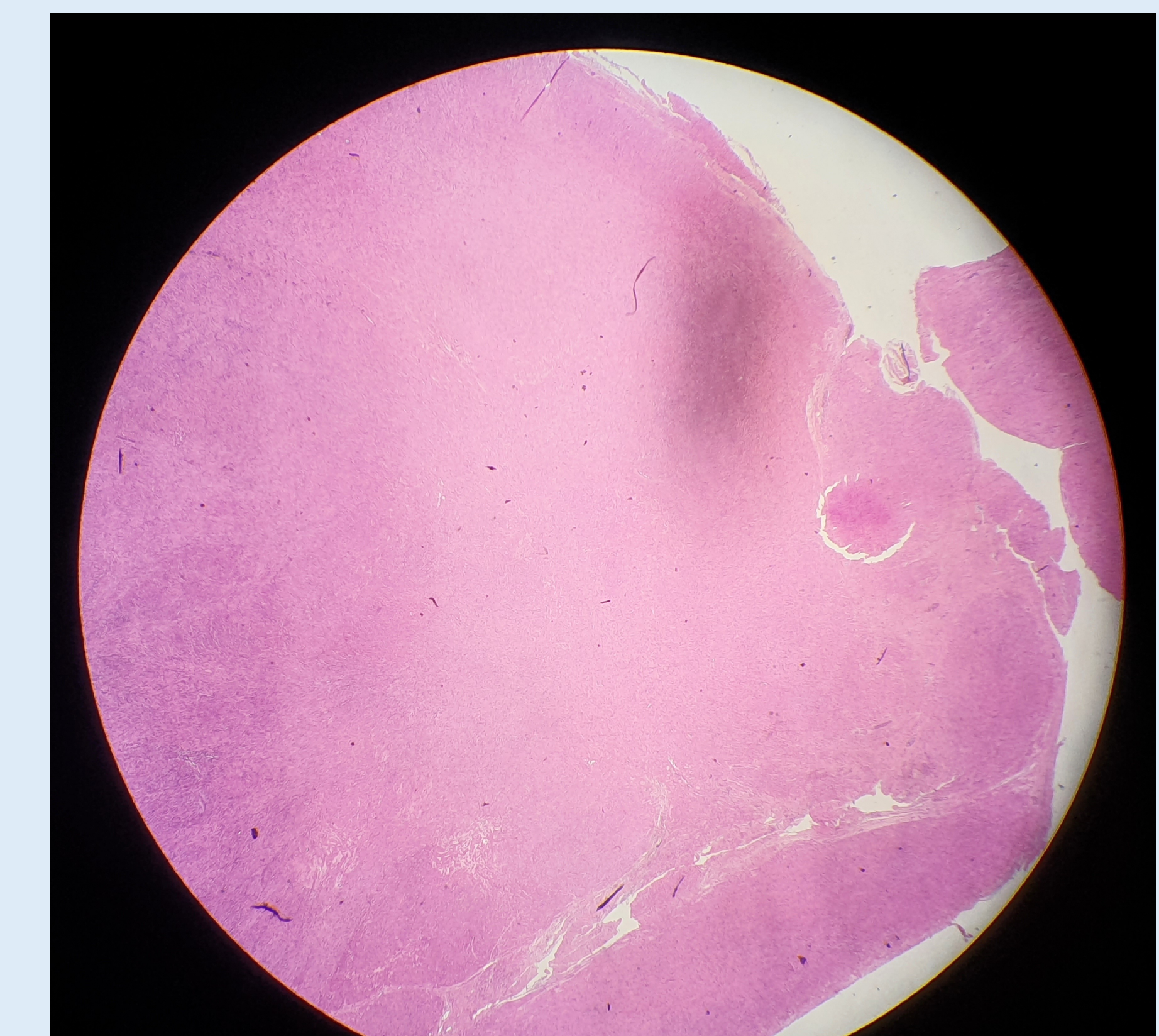
DISCUSSION

Vaginal wall leiomyomas are rare. They are thought to arise from Mullerian smooth muscle cells in the sub-epithelium of the vagina². They are asymptomatic initially; and may become symptomatic as the fibroid enlarges, causing symptoms such as abdominal pain, back pain, vaginal bleeding, dyspareunia, frequency of micturition, and symptoms of urinary obstruction¹. They are most commonly identified in women aged 35 to 50 years of age⁵, and in Caucasian women¹.

These fibroids usually arise from the anterior vaginal wall²; posterior vaginal wall fibroids are uncommon within the literature. Imaging, in the form of MRI, may aid diagnosis and surgical planning, as well as rule out sarcomatous changes³. Histological diagnosis, however, remains the gold standard¹. Surgical resection from the vaginal route appears to be optimal management, however good visualisation of the surgical plane is necessary⁶. GnRH analogues may be used to reduce the size of large vaginal wall fibroids prior to surgical excision⁴. These fibroids may recur, so follow up is required.

CONCLUSION

This rare case highlights the importance of good clinical examination and appropriate imaging when investigating vaginal wall masses. Multi-disciplinary working is essential to reduce the risk of complication when working beyond our area of expertise.



Histological appearance of benign leiomyoma

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